Assessment of Public Comments on the Revised Proposed Sixty-Third Amendment to 11 NYCRR 52 (Insurance Regulation 62)

The New York State Department of Financial Services ("Department") received comments from an insurer and associations that represent insurers and health maintenance organizations (collectively, "issuers") and a government agency. The commenters requested changes and expressed concerns about the revised proposed regulation's requirements. One issuer resubmitted comments from January 2022 that the issuer made on the original proposed regulation. However, the Department already addressed those comments in the assessment of public comments published in the State Register on August 17, 2022.

Comment: The revised proposed regulation requires that if an insured who is covered under an accident and health insurance policy that uses a network of health care providers receives a bill for out-of-network services resulting from an issuer providing inaccurate network status information to an insured, the issuer shall not impose on the insured a copayment, coinsurance, or deductible for the service that is greater than the copayment, coinsurance, or deductible that would be owed if the insured had received services from a participating provider. Several commenters expressed concern that the revised proposed regulation applies to stand-alone dental and vision insurance that use networks of health care providers. Those commenters stated that the federal No Surprises Act (the "Federal Act") does not apply to those types of coverages and that therefore, these provisions should be removed. One commenter noted that issuers have difficulty encouraging health care providers to participate in dental and visions networks and noted that if this revised proposed regulation exceeds the scope of the Federal Act, it would discourage issuers' efforts to introduce network-based stand-alone dental and vision insurance, to the detriment of New Yorkers.

Response: The Legislature did not limit the changes in Insurance Law Sections 3217-b and 4325 relating to provider directory misinformation to comprehensive health insurance policies. As such, the requirement for providers to reimburse insureds when an insured receives inaccurate network status information applies to stand-

alone insurance coverages, including stand-alone dental and stand-alone vision. The Department previously amended the regulation to clarify that the obligations on issuers when they provide inaccurate network status information apply to all accident and health insurance policies that use a network of health care providers, rather than only to comprehensive health insurance policies that use a network of health care providers. That previous change is an important consumer protection because it allows consumers to rely on network status information provided by an issuer without fear of owing more than the cost-sharing that would be owed to a participating provider. It also enables consumers who have stand-alone dental insurance to enjoy the same protections as consumers whose dental benefits are covered under their comprehensive health insurance policies. Therefore, the Department did not make any changes in response to this comment.

Comment: Several commenters objected to the application of the disclosure requirements in Insurance Law Sections 3217-a and 4324 to stand-alone dental and vision insurance. These commenters noted that the laws contain certain disclosure requirements that are not applicable to stand-alone dental or vision insurance, such as disclosure of prescription drug formularies, direct access to obstetrics and gynecological care, and the most recent analysis to provide services in accordance with the Mental Health Parity and Equity Addiction Act (42 U.S.C. § 18031(j)). The commenters requested that the Department remove Section 52.54(d) from the revised proposed regulation, or, in the alternative, identify the specific disclosure provisions of Insurance Law Sections 3217-a and 4324 that are appropriate for stand-alone dental and vision insurance.

Response: Insurance Law Sections 3217-a and 4324 contain disclosure requirements that apply to comprehensive, expense-reimbursed health insurance contracts, managed care health insurance contracts (including stand-alone dental and vision contracts), or any other health insurance contract or product for which the Superintendent deems such disclosure appropriate. Insurance Law Sections 3217-a and 4324 contain many basic disclosures, such as a description of coverage, benefits, benefit maximums, the insured's financial responsibility for premiums and cost-sharing, how the issuer handles the needs of non-English speaking insureds,

and provider directory information. These disclosures are necessary for insureds with stand-alone dental or vision insurance to understand their coverage and access to benefits. In fact, many of these disclosures relating to the scope of coverage are already provided by issuers in their stand-alone dental or vision insurance policies or certificates. Additionally, issuers already provide insureds with provider directory information. However, as the commenters stated, not all provisions of Insurance Law Sections 3217-b and 4325 apply to stand-alone dental and vision insurance. Therefore, the Department amended the revised proposed regulation to identify the specific disclosure requirements in Insurance Law Sections 3217-a and 4324 that apply to stand-alone dental and vision insurance, for clarity.

Comment: The revised proposed regulation requires an issuer to provide network status information to an insured in writing within one business day of the insured requesting the information by telephone. Several commenters indicated that if the Department intends to apply the revised proposed regulation to stand-alone dental and vision insurance, it should increase the timeframe for an issuer to provide a response to a request for provider network status information from one business day to three business days for stand-alone dental and vision insurance. The commenters stated that the Federal Act does not apply to stand-alone dental and vision insurance, and thus the one business day timeframe is not otherwise required. One commenter indicated that while stand-alone dental insurance issuers are making strides towards improving provider directories, the limited administrative capacity of stand-alone dental insurance issuers and dental providers inhibits their ability to comply with a one business day response requirement. Dental providers are more likely to use paper records and document systems compared to their medical counterparts, and often run solo practices with limited administrative staff. Dental issuers operate with significantly lower premiums than medical issuers and must manage their provider relations with significantly less resources than medical issuers. The commenters indicated that allowing for three business days to respond provides a more reasonable time to gather the information and confirm its accuracy.

Response: The Department concurred with this comment and amended Section 52.77(c) of the revised proposed regulation to increase the response timeframe from one business day to three business days for stand-alone dental and vision insurance.

Comment: Section 52.77(c) requires an issuer to respond in writing to a request for network status information. One commenter requested that Section 52.77(c) be amended to require that the response to a request for network status information also be transmitted electronically, using, for example, email or an online patient portal, enabling the insured to receive the information more quickly.

Response: The revised proposed regulation requires the response to a request for provider network status information to be in writing. "In writing" is not limited to sending a print response by U.S. Mail, but includes transmission by electronic means if the insured has consented in advance to such electronic communication. The Federal Act, however, specifically provides that the issuer may respond using written electronic or print (as requested by the insured) communication. Electronic communication includes communication by email or other Internet-based means like an online member portal. Thus, the Department amended the revised proposed regulation to clarify that electronic communication is included.

Comment: A commenter requested adding language to Section 52.77 to establish recordkeeping and documentation requirements for issuers regarding responses to provider network status requests, to reduce the burden on the insured to prove that inaccurate provider network status information was provided by the issuer. The commenter suggested that telephone call recordings and transcripts be kept on file for at least 120 days to hold issuer representatives accountable for the information provided.

Response: The Federal Act requires issuers to retain the response communication for provider network status information in an insured's file for at least two years following the provision of the response. However, Section 243.2(b)(8) of 11 NYCRR 243 (Insurance Regulation 152) requires issuers to maintain certain records for six years from creation or until after the filing of a report on examination or the conclusion of an investigation

in which the record was subject to review. The records demonstrating an issuer's compliance with this proposed regulation, including telephone recordings of requests for network status information and the issuer's written response, should be maintained in accordance with Section 243.2(b)(2), and thus the Department amended the revised proposed regulation to clarify.

Comment: A commenter requested that the Department add a new section outlining the grievance process for insureds improperly charged when an issuer provides inaccurate network status information. The commenter noted that insureds should be able to quickly and easily file complaints to ensure that they are fairly reimbursed and that their care is not interrupted by billing disputes.

Response: The grievance procedure, outlined in Insurance Law Section 4802, applies to managed care contracts, as defined in Insurance Law Section 4801(c), and any issuer that issues a comprehensive policy that uses a network of providers pursuant to Insurance Law Section 3217-d(a) and 4306-c(a). The grievance procedure permits an insured to seek review of determinations by an issuer regarding coverage or benefits under the policy and would include a grievance relating to an insured being improperly charged when an issuer provides inaccurate network status information. Further, the federal Department of Labor Claims Payment regulation in 29 C.F.R. § 2560.503-1 ("Federal Rule") establishes review procedures for claims, including internal appeals, and this regulation applies to comprehensive health insurance and group stand-alone dental and vision insurance. Thus, duplication of the grievance procedures and the claims procedures from the Federal Rule in the revised proposed regulation is unnecessary. Additionally, an insured may file a complaint with the Department's Consumer Assistance Unit at any time. The ability to file a complaint with the Department is not limited to instances when an issuer provides inaccurate network status information and thus it does not need to be duplicated in the revised proposed regulation.

Comment: Several commenters requested that the effective date for the revised proposed regulation for stand-alone dental and vision insurance be moved to at least six months after the adoption of the final regulation

to allow issuers providing stand-alone dental and vision insurance adequate time to implement the revised proposed regulation.

Response: The Department concurs with this comment and amended the revised proposed regulation to provide issuers of stand-alone dental and vision insurance with one year to revise their provider contracts and otherwise implement the final regulation before it applies to stand-alone dental and vision insurance. The Federal Act applied to comprehensive health insurance for plan years beginning on or after January 1, 2022. Thus, the effective date for comprehensive health insurance is not being changed.